STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155721	A. BUILDING _____ B. WING _____	C 07/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE MANOR HEALTHCARE CENTER	**8935 E 46TH ST INDIANAPOLIS, IN 46226**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00151088.

Complaint IN00151088 - Substantiated. No deficiencies related to the allegations are cited.

Survey Date: July 8, 2014

Facility number: 000383
Provider number 155721
AIM number: 100289610

Survey team:
Tom Stauss, RN-TC
Beth Walsh, RN

Census bed type:
SNF/NF: 48
Total: 48

Census payor type:
Medicare: 6
Medicaid: 32
Other: 10
Total: 48

Sample: 03

Lawrence Manor was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00151088.

Quality review completed on July 10, 2014; by Kimberly Perigo, RN.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE